Norfolk Community Services Board
Consumer Relations / Investigation Summary

I. Description of Incident:

Allegation:	12VAC35-115-50. Dignity. B. 2. Be protected from harm including abuse, neglect and exploitation.
Date Complaint Received:	11-16-18
Staff Involved:	Multiple staff at the Virginia Beach Blvd. location
Consumer:	E.D. #245090 and M.C. #672770
Program Site:	Virginia Beach Blvd. location, front lobby
Supervisor:	Ms. Chandra Beasley, MHCH Program Manager Ms. Lydia Kim, Intake Program Manager

II. Summary of Incident:

The Compliance Team received two incident reports on 11-15-18. The first one was from Mr. Randy Plante, PACT Program Administrator and the second one was from Ms. Carrington, who works at the front desk at the Norfolk Community Services Boards (NCSB) Virginia Beach Boulevard Center (VBBC).

Mr. Plante:

"This PACT staff was informed by other PACT staff that PACT client E.D. #245090 was physically assaulted in the lobby at the VBBC. Upon arriving at the scene, this writer observed the client lying on the floor bleeding from nose and mouth. Client was receiving medical attention from NCSB psychiatrist. Norfolk Fire and Rescue arrived at the scene and transported the client to Sentara Norfolk General Hospital. Norfolk police arrived and took the suspect into custody. This writer met with the client's medical doctor at Sentara and was informed that the client's CT of his head was negative and that he suffered no facial or head fractures. However, the medical doctor informed this writer that the client was having breathing problems and was non-responsive. As a result, a breathing tube was provided, and an EEG was ordered. The doctor believed that the client was having a seizure which would cause him to be non-responsive."

Ms. Carrington:

"Client arrived at approximately 8:30AM for an intake assessment with his mother present. When he began raising his voice and yelling inside the building to no one in particular, several NCSB staff came to talk to client and assess. Denise Brown from MHCM (Mental Health Case Management) called Emergency Services and was informed that they were unable to come out and assess client because he did not seem to meet

criteria for a TDO. Client's mother called Norfolk Police who responded at the scene and left after stating that he has not committed a crime or hurt anyone. Client and client's mother were taken back for an intake assessment with clinician, Molly LaRocco, LPC and despite disparaging remarks to the clinician, client did not behave or verbalize anything that warranted another call to Emergency Services. While client and his mother were waiting in the 1st floor lobby of the VBBC to meet with a financial assessor, client began pacing the lobby and struck another client who was standing at the front desk waiting for someone from his PACT team. The victim was knocked down to the floor and was repeatedly stomped on his head and hit in the head with a chair. Jacqueline Watkins and Kayla Auxier heard the commotion and guided the violent client out of the main VBBC front door and subsequently locked it to prevent client's re-entry. Client continued to yell and threaten to hurt people from the other side of the door. Dr. Forte and Dr. Bolten provided medical assistance to the victim in the main lobby. During the assault, this writer called 911 while another support staff member, Juanita Teague, pressed the panic button to alert police. Norfolk Police arrived on the scene and arrested the aggressor. An ambulance arrived and transported the victim to Sentara Norfolk General Hospital."

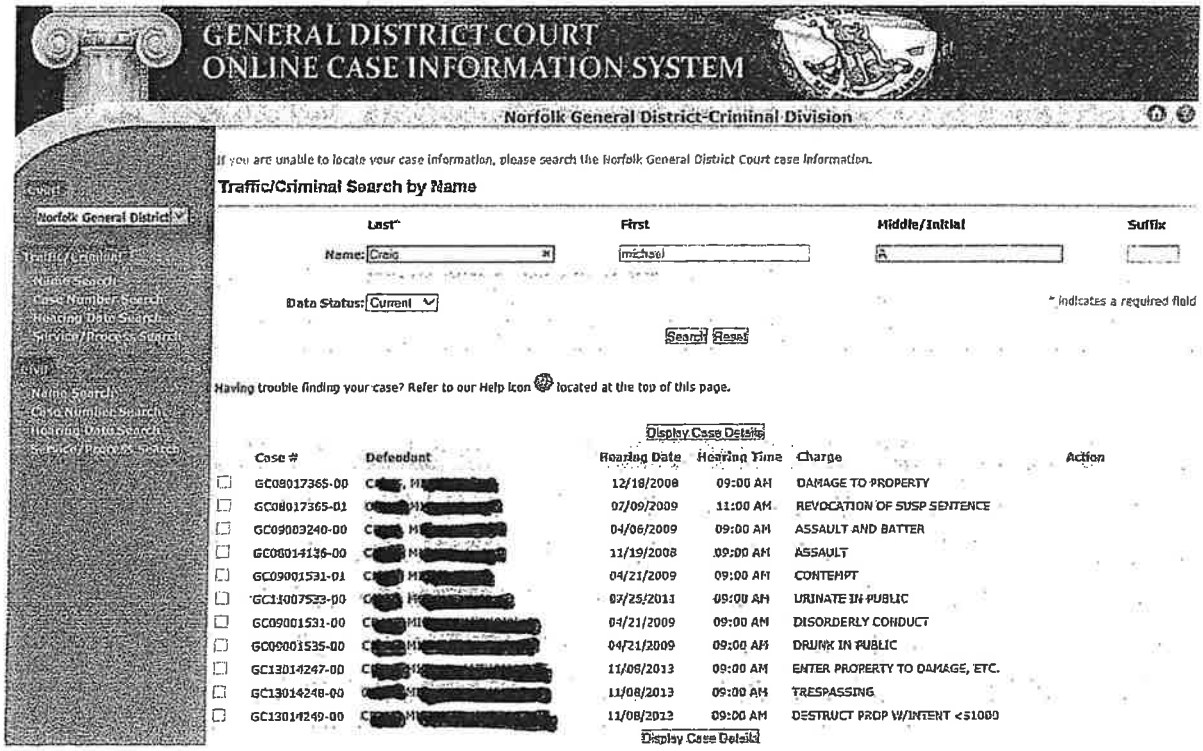
Due to this incident occurring between two peers within a NCSB location, it was reported to CHRIS as a peer to peer allegation for possible abuse/neglect (#20180019). It was also reported in CHRIS as a critical incident (#20180172). This investigation will focus on the allegation of possible neglect on the part of the NCSB when the peer-to-peer assault occurred on 11-15-18.

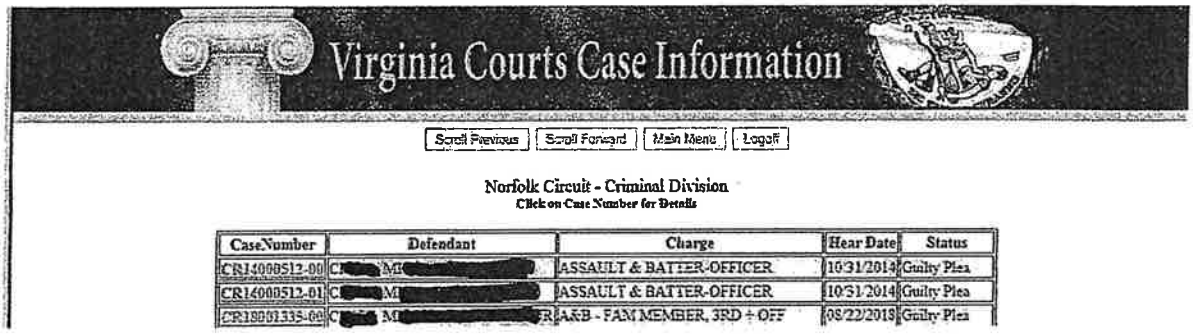
III. M.C. #672770 Profiler Timeline of Services at NCSB:

- 10-17-12: Emergency Services (ES) - TDO was sought.
- 11-26-12: Intake.
- 1-15-13 until 4-17-13 MHCM: Received CM Assessment; MHCM referred to ICARE; consumer closed due to lost to contact.
- 1-28-13 until 3-25-13: ICARE - Initial Psychiatric note for 30 minutes but there is no written note. MHCM notes document that is was a no show; M.C. never saw an ICARE Psychiatrist and was closed on 3-25-13.
- 6-9-15: Intake; GAP assessment was completed but the consumer left waiting area before intake was done.
- 6-9-15 until 6-18-15: Care Coordination - attempted to reach out but closed after lost to contact.
- 7-9-15: Intake - No assessment completed; Note states that consumer scheduled an appointment with "a psychiatrist of choice and was encouraged to actively discuss his concerns with his doctor."

- 7-9-15 until 9-18-15: Care Coordination - Closing note says GAP application and Intake assessment completed, on 7-9-15 but there is nothing in profiler from that date.
- 11-29-16: ES - Progress note states see Pre-Screening Admission form but was unable to locate in Profiler.
- 4-28-17: ES - Did not meet criteria for TDO.
- 3-8-18: ES - Screened at Jail; consumer refusing meals; TDO was recommended.
- 3-30-18 until 8-23-18: Jail Liaison - Open to the cost center in Profiler but no notes documented.
- 11-15-18: Intake - Date of incident.

IV. Criminal History on M.C.:





V. **Timeline of Events on 11-15-18:**

- M.C. came into the VBBC lobby around 8:30am with his mother.
- Prior to the Intake Assessment:
  - Mom completed the paperwork with Ms. Carrington at the front desk.
  - M.C. left the lobby and ran after another person walking on the sidewalk by the road, reportedly stating that the person was talking about him.
  - Mother called the Norfolk Police Department (NPD) due to her concerns about his behavior after he ran towards a person on the street. NPD stated that they did not have a reason to detain M.C.
  - Ms. Brown was called by front desk due to M.C. yelling, pacing, and using inappropriate language in the lobby and hallway. Ms. Brown came down and called Emergency Services (ES). She asked for "guidance". ES did not hear that a pre-screening was being requested.
  - Ms. Brown relayed concern about M.C.'s behavior to her supervisor, Ms. Beasley. They met with Ms. Kim, Intake Program Manager, and informed her of M.C.'s behavior.
  - Ms. Kim asked that Ms. Jordan from Top Guard sit in the waiting area of Intake and that Ms. LaRocco, the Intake assessor, be asked to keep her door open while M.C. and his mother were in her office.
    - Ms. Jordan did sit in the Intake waiting area. However, no one relayed information to Ms. LaRocco about keeping her door open due to behavioral concerns about M.C.
    - Ms. Kim was not able to intervene herself due to a scheduled presentation for staff on the 2nd floor.
- Intake Assessment, initiated at approximately 8:50am.
  - Ms. LaRocco reported that she had M.C. in her office about 20 minutes and then ended the session because she felt "uneasy" with him in her office. The Intake was not completed.
  - Following Ms. LaRocco assessment with M.C., she relayed information to Ms. Gordon, who was scheduled to complete his financial assessment.
- Financial Assessment:
  - Ms. Gordon reported that after hearing concerns about M.C.'s behavior from Ms. LaRocco, she opted to complete the majority of the paperwork without him present in the room. Once that was completed, she brought M.C. and his mother into her office for explanation and signatures. M.C. paced in and out of the room. His mother took the opportunity to tell Ms. Gordon and her co-worker that she was fearful of M.C. She also reported that he had tried to jump out of the car while coming to the NCSB that day. From her report, M.C. was angry with children at a bus

stop because he thought they were talking about him, so he tried to get out of the car and go after them.

- Ms. Gordon completed her financial process and then told the front desk staff to call MHCM right way, stating that they needed finish the process because M.C. was "agitated".

- Mental Health Case Management (MHCM):
  - While Ms. King from MHCM was on her way downstairs to conduct the intake, M.C. initiated physical aggression towards E.D. in the lobby area. E.D. had been standing at the front desk with headphones on. He was unaware of the approaching aggression by M.C.
  - Dr. Forte and Dr. Bolten provided first aid to E.D. while waiting for the paramedics to arrive.

VI. Summary of Interview:

Top Guard Security, Ms. Marsha Jordan:

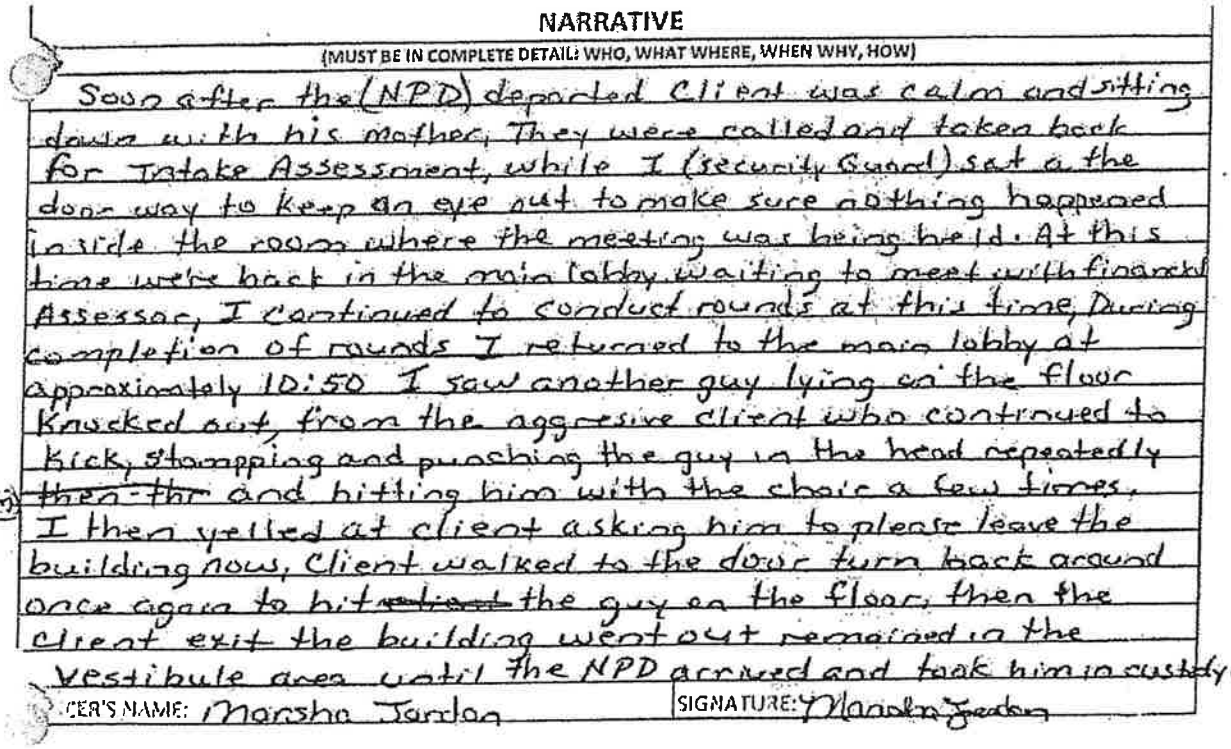
Ms. Jordan submitted two Top Guard reports, which stated the following:

NARRATIVE

(MUST BE IN COMPLETE DETAIL: WHO, WHAT WHERE, WHEN WHY, HOW)

On November 15, 2018 Client arrived at CSB on E. Virginia Beach Blvd at approximately 8:30 a.m. for an Intake Assessment with his mother, While waiting to be seen client walked outside of the building, When Intake called for him I M. Jordan went outside to get the client to come in. And the client was yelling at another gentleman who was walking along the highway towards P.O.D. The client went chasing the gentleman down the highway. When the client returned back to CSB he stood in the lobby talking out loud to himself pacing the floor walking back & forth to - Integrated Care then the lobby. At this time client's Mother stated he needed help right away before this gets out of hand Mother repeatedly said to staff she could not take him home with her, she was afraid and feared for her life. The the mother called (911) they arrived to CSB to assist the mother and told her there was nothing they could do, if client did not commit a crime or hurt anyone. And then departed building

OFFICER'S NAME: Marsha Jordan SIGNATURE: Marsha Jordan



NARRATIVE

(MUST BE IN COMPLETE DETAIL: WHO, WHAT WHERE, WHEN WHY, HOW)

Soon after the (NPD) departed Client was calm and sitting down with his mother, They were called and taken back for Intake Assessment, while I (Security Guard) sat a the door way to keep an eye out to make sure nothing happened inside the room where the meeting was being held. At this time were back in the main lobby waiting to meet with financial Assessor, I continued to conduct rounds at this time, During completion of rounds I returned to the main lobby at approximately 10:50 I saw another guy lying on the floor Knocked out, from the aggresive client who continued to kick, stomping and punching the guy in the head repeatedly ~~then the~~ and hitting him with the chair a few times, I then yelled at client asking him to please leave the building now, Client walked to the door turn back around once again to hit ~~client~~ the guy on the floor, then the client exit the building went out remained in the vestibule area until the NPD arrived and took him in custody.

OFFICER'S NAME: Marsha Jordan SIGNATURE: Marsha Jordan

VBBC Staff:

Many staff members were witnesses to the event that occurred on 11-15-18 between the two peers, E.D. #245090 and M.C. #672770. In order to gain information concerning the event of that morning, the following staff were interviewed due to their firsthand knowledge and involvement with M.C.:

- Marsha Jordan, Top Guard Security
- Linda Carrington, Front desk person
- Denise Brown, MH CM Supervisor
- Tareka White, Emergency Services, with her supervisor, Ms. Kristen Condron
- Molly LaRocco, LPC, Intake Clinician
- Verna Gordon, Benefits
- Kayla Auxier, Nurse
- Jacqueline Watkins, Intake Practice Manager
- Jennifer King, MH CM Supervisor
- Rachel Greenburg, Court Liaison

In general, their memory of the events that took place that day were consistent. They all described M.C.'s behaviors in the lobby as psychotic, hearing voices, yelling, loud, disruptive and pacing. During his aggression towards a peer, E.D., his actions were described as hitting, kicking, stomping, swinging chairs, actions with the intent to "kill".

In addition, each individual had their own details of the event. The following information was extracted from their interviews.

1. Ms. Jordan completed a Top Guard report but also stated that she had been on rounds when she came around the corner and saw E.D. on the ground with M.C. kicking, stomping, and punching on his head. She was not in the immediate area when the physical aggression towards E.D. was initiated. She did report M.C.'s behaviors prior to his Intake appointment involved pacing, talking loudly to himself, and running after another person outside. Ms. Jordan was informed by the mother early in the morning that she was "fearful for her life".

2. Ms. Carrington confirmed that M.C.'s mother completed his paperwork and when it was time for his Intake, M.C. was missing from the lobby. His mother reported that he left and ran down the street. She remembered thinking that this information was not out of the ordinary. In her experience, family members bring individuals who do not want to be there, so they leave before their appointment, which is what she assumed M.C. had done that day. She was aware that the mother called police and that M.C. returned to the lobby.

   She called Ms. Brown when M.C. started yelling in the lobby, pacing, and talking to himself. He was talking loudly about his history of being sexually molested while walking back and forth from the lobby to ICARE. Ms. Carrington realized that something "was wrong" when Ms. Brown asked Ms. Jordan from Top Guard to sit in the Intake lobby while M.C. was in the office with the clinician, Ms. LaRocco.

   Ms. Carrington also assisted Ms. Gordon by calling Ms. King down to the waiting area after his financial assessment was completed. At that point, M.C. was reported as being agitated and psychotic. While waiting on Ms. King to come down and complete the MHCM assessment, M.C. physically assaulted E.D. right in front of Ms. Carrington's desk area. She called 911 while another front desk employee activated the panic button.

3. Ms. Brown came down to the front lobby at VBBC when she heard that "something was going on". Ms. Brown talked with M.C.'s mother and learned that he had tried to jump out of the car while they were on the way to VBBC because he thought the kids were talking about him. He also ran after a man at the bus stop in front of VBBC after arriving at the building, for the same reason. Ms. Brown was informed the police had been involved with M.C. that day at the mother's request. Ms. Brown also opted to call Emergency Services (ES) to seek guidance. She reported that her desire was to have ES come to the building to

pre-screen M.C. Ms. Brown stated that ES told her they could not send anyone to "sit with him" but she was encouraged to have a staff remain with him so that he could be compliant for his Intake appointment. Ms. Brown then remembers M.C. pacing back and forth from the lobby to ICARE, preaching to people and talking about things of a sexual nature.

At that point, Ms. Brown called her supervisor, Ms. Beasley, and the two of them talked with M.C.'s mother. She reported M.C. as being calm at that time so they met briefly with Ms. LaRocco, the clinician who would be conducting his Intake. They also found Ms. Kim, the Intake Program Manager, and informed her of the events of the morning with M.C. At Ms. Kim's request, Ms. Brown asked Ms. Jordan with Top Guard to sit in the Intake waiting area while M.C. was in Ms. LaRocco's office. When interviewed, Ms. Brown could not recall if Ms. LaRocco was fully aware of all the events that occurred with M.C. that morning.

4. Ms. White, an Emergency Services pre-screener, stated that she received a telephone call from Ms. Brown at VBBC, stating that she had a "question". Per Ms. White, Ms. Brown stated that they had M.C. in the lobby and he "won't sit and was talking to people". When asked if M.C. had been seen for Intake, Ms. Brown said "No". Ms. White stated that Ms. Brown "definitely did not" ask for a prescreen. Instead, she heard Ms. Brown asking a question of what to do. Ms. White recommended redirecting him and having a person sit with him.

5. Ms. LaRocco, an Intake clinician, immediately reported during her interview that she was not informed of everything that had occurred earlier in the morning with M.C. She arrived at work around 8:40am and saw the police with M.C.'s mother. She saw and heard M.C. yelling into the ICARE waiting room about sexual things. Ms. LaRocco also reported that Ms. Carrington asked her to take him into her office for his Intake appointment because he was "agitated".

   Ms. LaRocco reported that no one told her that Ms. Jordan from Top Guard was sitting in the Intake waiting area while M.C. and his mother were in her office for the assessment. She later found out that her supervisor, Ms. Kim had asked that she be told to keep her office door open during the assessment. That message was never relayed to Ms. LaRocco.

   Per Ms. LaRocco, M.C. was agitated and attempted to "bait her" by looking for a reaction. She reported that he was actively psychotic, hearing voices, and difficult to engage in the process. Due to these factors and having a sense of uneasiness with being in the same, small room with M.C., Ms. LaRocco did not conduct the Intake assessment and led him out of her room after about 20

minutes later. She reported that she informed Ms. Gordon, who was going to complete his financial assessment, of his psychotic, aggravated disposition, encouraging her to complete the process as quickly as possible.

While engaged in the next consumers Intake Assessment, Ms. LaRocco heard screaming in the front lobby and made the choice to keep herself and the consumer safe in her office. She was not aware at that time that the violent behaviors came from M.C. towards another consumer.

6. Ms. Gordon reported that Ms. LaRocco brought M.C.'s file to her for the financial assessment. She informed Ms. Gordon that M.C. was hearing voices and using threatening words. When signing paperwork in her office, Ms. Gordon reported that M.C. walked in and out of her office. He made threatening comments on several occasions and his mother, who was also in the office, verbalized her fear of him.

   After completion of the financial assessment, she asked that Ms. King from Mental Health Case Management be called right away. Due to his agitation, Ms. Gordon thought Ms. King should quickly complete her assessment so that he could leave the building. In that moment, M.C. engaged in physically assaulting E.D. who was standing at the front desk with ear phones in, unaware of people or noises in his environment.

7. Ms. Auxier, a nurse working with PACT that day, stated that she left the PACT office to retrieve something from her car. When she came out of the office and walked towards the lobby, she heard screaming and witnessed M.C. assaulting E.D., who was laying on the floor.

   Ms. Auxier reported that M.C.'s mother was the only one who put their hands on him when he was "violently" hitting, kicking, stomping, and swinging chairs at E.D. She also remembers another client in the lobby pulling a chair in front of him because he was scared of M.C.'s "explosive" behavior when he started yelling at him as well. Ms. Auxier reported that she, Ms. Watkins, Ms. Gordon, and his mother were able to maneuver M.C. back out the lobby door. Once outside, they locked the door and M.C. began yelling and screaming verbal threats towards Ms. Carrington. He also aggressively beat on the glass door.

8. Ms. Watkins became aware of the assault when she heard screaming from the front lobby and saw the front desk staff physically learning over the counter. She reported that she had heard M.C. talking loudly earlier in the morning. When Ms. Watkins left her office and walked into the lobby area, she said she saw a man "lifeless" on the floor, while M.C. was kicking and stomping his head.

At one point, Ms. Watkins remembers M.C. stepping away, which was when she leaned over E.D., pulled his hoody back and saw his bloody, swollen face. She backed away when the aggressor came back and continued to physically assault E.D. By her report, this all happened very quickly.

She worked together with Ms. Gordon from Top Guard, Ms. Auxier, and his mother, to back M.C. away from E.D. and towards the front door. Once he was on the other side, Ms. Watkins locked the door behind him.

9. Ms. King was scheduled to see M.C. that day for same day access into MHCM Services. Usually those appointment are scheduled at a certain time but on that day, she received a call from the front desk, asking her to come down right away to see M.C. due to his agitated presentation. It was her understanding that staff were eager to have him finish and leave the building. She was aware of earlier events, as Ms. Brown her co-worker, intervened with M.C. prior to his Intake appointment.

   As she approached the front lobby, she saw M.C. physically assaulting E.D., who was laying on the floor. She remembered calling out that someone should call 911. Ms. King used the words "violent" and "rage" when reporting what she saw that day with M.C.

10. M.C. was referred to Intake on 11-15-18 from the jail/court system, which was where Ms. Greenburg, NCSB's Court Liaison became involved. She was interviewed in order to gather her impressions of M.C. when she met with him after his court hearing on 11-5-18. She spoke with both M.C. and his mother at that time. As she recalled, M.C. was "disconnected" and appeared to be hearing and responding to voices. He had not been aggressive in the court building that day and was not aggressive in her office, but was not interactive with her. Ms. Greenburg was able to pull up his legal charges, as shown above in M.C.'s legal timeline. She was aware of his physical aggression primarily towards his mother and his unpredictable behavior.

    Ms. Greenburg assisted with sending them to the VBBC for an Intake Assessment at the NCSB. She remembers calling over to VBBC and informing "someone" that he was scheduled for 11-15-18 but stated that she did not think that there were any additional notes that should have been presented prior to his Intake appointment. Ms. Greenburg stated that she primarily works with adolescents in the court system but assists the judges when an adult needs MH services from the NCSB. She does not have a specific contact person at VBBC who she calls when making appointment arrangements.

It should also be noted that each individual reported heightened awareness of M.C. due to audible and visual behaviors, comments from his mother, and police involvement as soon as he arrived at VBBC. Because of their observations, additional interventions were put in place and explored in order to provide support to M.C. and his mother that day.

1. Ms. Jordan from Top Guard was alerted to M.C. when he first arrived, ran out of the building, and then NPD arrived at the mother's request. Ms. Jordan also provided additional security for the Intake clinician by sitting inside the Intake waiting area while M.C. was in his assessment.
2. Ms. Carrington at the front desk, called Ms. Brown from MHCM when M.C. appeared to be agitated. That intervention was put in place and to support M.C. and his mother. Ms. Brown is a supervisor with MHCM and has many years of experience working with individuals who are challenged with mental health symptoms. Ms. Carrington also called 911 as soon as the physical assault took place.
3. Ms. Brown came down to the lobby when called by Ms. Carrington and talked with M.C and his mother. Her concern led to an Emergency Services (ES) call for guidance, which was an appropriate intervention. She also consulted with her supervisor, Ms. Beasley, which led to an additional consultation with Ms. Kim, Program Manager of Intake.
4. Molly LaRocco, LPC, Intake Clinician, allowed her clinical judgement to guide her actions while attempting to conduct an Intake Assessment with M.C. and his mother in her office. When she became aware that the process was not attainable due to his mental status at that time, she ended the session and shared her observations with the next staff person who was scheduled to see M.C.
5. Ms. Gordon attempted to make her financial assessment with M.C. as concise as possible and notified Ms. King from MHCM when she observed his increased agitation.
6. Ms. Auxier and Ms. Watkins both responded to the immediacy of the crisis by supporting Ms. Jordan, from Top Guard, as they attempted to back M.C. out of the building after his assault on E.D. They both acknowledged that they did not put hands on M.C., which is within the guidance they have received through NCSB's training, Crisis Prevention Institute (CPI).

In summary, Top Guard Security, NPD, ES, additional staff from MHCM and Intake, and additional conversations took place on 11-15-18 in order to support M.C. and his mother during their Intake appointment that day.

VII. Findings:

- This investigation is based on a possible violation of the Human Rights Regulation "12VAC35-115-50. Dignity. B. 2. Be protected from harm including abuse, neglect and exploitation". Every consumer has the right to a safe environment, free from harm. On 11-15-18, E.D. was physically assaulted by another consumer, M.C., in the lobby of the VBBC. Therefore, abuse of a consumer did occur.
- In the definition section of the Human Rights Regulations, 12VAC35-115-30, "Peer to Peer aggression" is defined as a "means of a physical act, verbal threat, or demeaning expression by an individual against or to another individual that caused physical or emotional harm to the that individual. Examples includes hitting, kicking, scratching, and other threatening behavior." The definition goes on to say, "such instances may constitute potential neglect", which would be neglect of staff surrounding the event. It is the responsibility of this Human Rights investigation then, to focus on acts of neglect, disregard, or abandonment by NCSB staff while acknowledging that abuse did occur.
- In review of the human rights allegation of possible neglect during this event, staff provided additional measures in order to support M.C. during his Intake appointment. They utilized their resources and put interventions in place within the boundaries of the service setting. They did not act neglectfully while attempting to provide M.C. with mental health support. They did not act with disregard towards M.C. when he showed symptoms of agitation. They did not abandon M.C. in the lobby of the VBBC once he arrived for services. Although it was reported that M.C.'s behaviors prior to that altercation were concerning, his violent physical aggression towards E.D. in that moment on 11-15-18 were unpredictable and random to those involved in his services.
- Due to evidence that staff were not neglectful in their attempts to assist M.C. on 11-15-18 and the unpredictable nature of the physical aggression that took place towards E.D., the allegation that NCSB staff were neglectful in their actions during this peer-to-peer altercation is unsubstantiated.

VIII. Recommendations:

- Due to this peer to peer physical abuse case, several changes and opportunities have been put in place:
    - NPD CIT officers have been stationed in the VBBC lobby for added security for an unknown period of time.
    - Activities, such as adult coloring books, have been added to the lobby while consumers wait for their appointments. Snack food and water have also been added to the lobby for consumers.
    - MHCM supervisors are providing additional supervision and assistance to the staff at the front desk and to consumers as they enter the building.

- Certified Peer Specialists have provided one-on-one support to consumers as they enter the building and move throughout the various programs.
- PACT consumers are being brought up to the PACT waiting area on the second floor, which reduces the population in the lobby.
- ICARE consumers are being directed to the ICARE lobby.
- Mental health support and crisis debriefings are taking place at VBBC for all staff.
- PACT staff continue to monitor E.D.'s recovery and support the family.